

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Women's Way	CHAPTER 98
Address: 845 22 nd Avenue Honolulu, Hawaii 96816	Inspection Date: March 25, 2019 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-98-11 <u>Minimum standards for licensure: personnel.</u> (e) There shall be documented evidence that every employee has a pre-employment and an annual health evaluation by a physician. These evaluations shall be specifically oriented to determine the presence of any infectious disease liable to harm a resident. Each health evaluation shall include a tuberculin skin test or a chest x-ray.</p> <p><u>FINDINGS</u> Employee #2 – No documented evidence of annual tuberculosis clearance.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-98-11 <u>Minimum standards for licensure; personnel.</u> (e) There shall be documented evidence that every employee has a pre-employment and an annual health evaluation by a physician. These evaluations shall be specifically oriented to determine the presence of any infectious disease liable to harm a resident. Each health evaluation shall include a tuberculin skin test or a chest x-ray.</p> <p><u>FINDINGS</u> Employee #2 – No documented evidence of annual tuberculosis clearance.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-98-12 <u>Minimum standards for licensure; services.</u> (5) Individual records shall be kept on each resident which contain the following:</p> <p>Documentation that a physician was consulted within five days of admission as well as for all significant illnesses and injuries;</p> <p><u>FINDINGS</u> Residents #2, #3, & #4 – Physician was not consulted within five (5) days of admission.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-98-14 <u>Physical facility.</u> (c) Maintenance. Facilities shall be maintained in accordance with provisions of state and county zoning, building, fire, safety and health codes in the State.</p> <p><u>FINDINGS</u> Cottage #2 Room 15 – Light bulb not working. Cottage #3 Room 5 – Light bulb not working.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-98-14 <u>Physical facility.</u> (c) Maintenance. Facilities shall be maintained in accordance with provisions of state and county zoning, building, fire, safety and health codes in the State.</p> <p><u>FINDINGS</u> Cottage #2 Room 15 – Light bulb not working. Cottage #3 Room 5 – Light bulb not working.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p>	

Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____